Cover Sheet

Testimony of: The National Association of Rural Health Clinics

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Representing: National Association of Rural Health Clinics
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Testimony is presented in support of funding for:

Rural Outreach Grants: The program encourages the development of innovative collaborative delivery mechanisms in small rural hospitals. Recommendation: $38 Million
Hospital Flex Program: The program provides rural hospitals with the resources they need to make better decisions about how they operate. Recommendation: $ 25 Million
Small Rural Provider Grants: The program supports the development of Quality Assurance programs in small rural providers such as Rural Health Clinics and Critical Access Hospital. Recommendation:$10 Million

These funds are administered by the Health Resources and Services Administration's Office of Rural Health Policy and support improved access to quality health care in rural areas. In addition, these funds support innovative delivery systems in rural communities.

Mr. Chairman and Members of the Labor-HHS Appropriations Subcommittee.

My name is Dennis Geitner and I am the President of the National Association of Rural Health Clinics (NARHC). On behalf of NARHC and the more than 3,400 federally certified Rural Health Clinics, I want to thank you for this opportunity to testify.

In addition to my role as the volunteer president of NARHC, I am the Director of Recruitment and Retention at Charles Cole Memorial Hospital in Coudersport, Pennsylvania. We are a small 70 bed rural hospital with 10 federally certified Rural Health Clinics. Our hospital and clinics serve a multi-county region along the Pennsylvania/New York border in north central Pennsylvania.

Each of our 10 Rural Health Clinics is located in a medically underserved area and provides high quality, cost-effective primary care in their respective communities.

I am here today to urge this Subcommittee to provide funds for the vitally important rural outreach programs run out of the federal office of rural health policy.

Mr. Chairman, in the Fall of 2002, Congress approved the Health Care Safety Net Improvement Act. This bill was signed into law by President Bush on October 26, 2002. Included in that important legislation was a reauthorization of some pre-existing rural health grant programs, as well as authorization of a new grant program for Rural Health Clinics (RHC) and Critical Access Hospitals (CHA) for the development of quality assurance programs.

Unfortunately, the President's 2005 budget failed to include any money for the rural hospital flexibility program, recommended reducing the funds for the rural outreach grants and provided no funding for the new RHC/CAH quality assurance grants. We strongly recommend that Congress reject the President's budget proposal and fund these important rural health programs.

As you may know, on December 24, 2003, the Centers for Medicare and Medicaid Services (CMS) published new regulations for the Rural Health Clinic program. Included in these regulations was a requirement that all Rural Health Clinics develop and implement a quality assessment program improvement (QAPI) initiative. Mr. Chairman, this is a unique requirement. No other primary care provider is obligated under the requirements of the Medicare program to undertake this type of activity.

When the House and Senate recommended the creation of this new grant program for RHCs and CAHs, it was with the knowledge that the new QAPI requirements were in the process of being finalized. The grant funds were intended to assist RHCs with the development of these QAPI initiatives and create a body of information that other RHCs could draw upon.

If the President's budget recommendation is adopted, we in the RHC community are faced with the reality of the QAPI requirements, but no resources to assist RHCs in meeting these requirements.

At Charles Cole, we have been fortunate that our leadership has made internal resources available to help us develop some initiatives that we believe will put us in compliance with the QAPI requirement. However, not all RHCs are as fortunate as us. Many clinics are small facilities with limited staff and more importantly, limited resources. Some Rural Health Clinics are only open for one or two days a week in some of the most remote areas of the country. These clinics will need these grant dollars to assure their ability to comply with this new requirement.

Mr. Chairman, rural providers need the outreach grant program, the flex program and the quality assurance grant program in order to have the resources necessary to improve service delivery in their communities. We are struggling. The Medicare Payment Advisory Commission has noted that while margins are down across the board, the decline has been particularly steep for rural hospitals and rural providers.

Rural Outreach

The program funds demonstration grants. The grants last three years and applicants can receive up to $200,000 a year. The intent of the grants is to provide start-up funding for innovative approaches to addressing health care problems in rural communities. A recent study by the University of Minnesota found that more than 80 percent of Outreach grants were still operating five years after Federal funding. We urge funding of $38 Million in FY 2005 for this program.

Hospital Flex

In essence, the program provides rural hospitals with the resources they need to make better decisions about how they operate. Unlike urban hospitals, which are often part of larger health systems with ready access to capital for consulting and business services, rural hospitals face challenges in responding to an ever-changing health care environment. Restore funding of $25 Million for this program.

Small Rural Provider Grants (RHC & CAH)

The grant funds are intended to assist RHCs with the development of QAPI initiatives and create a body of information that other RHCs could draw upon. We recommend initial funding of this initiative of $10 Million for this program. It is expected that the typical quality assurance grant would be for amounts less than $50,000 per clinic or CAH. Therefore, we believe an initial funding level of $10,000,000 could fund between 200 and 300 QA projects.

Mr. Chairman, rural Americans face a wide variety of problems in ensuring access to needed health care services. They are sicker, poorer, less likely to have health insurance and more likely to pay more for health insurance then their urban counterparts. They also must travel longer for their care and face greater delays in getting access to care than Americans in urban and suburban areas.

While provisions in the Medicare legislation passed last year will help many rural hospitals, there is little in that bill that will help Rural Health Clinics. It is imperative that we provide resources to providers, such as Rural Health Clinics, established in rural underserved areas so they can remain in those communities.

Mr. Chairman, the Rural Health Clinics community recognizes that the federal budget is tight. We do not make this request lightly. However, we believe that an investment of the amount mentioned above would result in significant improvement in the quality of health care available in rural underserved areas.

Your consideration of this request is greatly appreciated. I would be happy to answer any questions you might have.